MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

RESPIRATORY MEDICAL QUESTIONNAIRE

OTSG APPROVED *(Date)* *(YYYYMMDD)* **4 MAR 98**

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respiratory (please print).

1. Today's date:
2. Your age (to nearest year):
3. Sex (circle one): Male/Female
4. Your height: ft. in.
5. Your weight: lbs.
6. Your job title:
7. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
8. The best time to phone you at this number:
9. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
10. Check the type of respirator you will use (you can check more than one category):
    - ☐ N. R. or P. disposable respirator (filter-mask, non-cartridge type only).
    - ☐ Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus.)
11. Have you worn a respirator (circle one): Yes/No
    If "yes," what type(s):

Part A. Section 2. (Mandatory) ***Questions 1 through 9*** below must be answered by every employee who has been ***selected to use any type of respirator*** (circle Yes or No)

1. Do you currently smoke tobacco or have you smoked tobacco in the last month? Yes/No
2. Have you ever had any of the following conditions?
    a. Seizures (fits): Yes/No
    b. Diabetes (sugar disease): Yes/No
    c. Allergic reactions that interfere with you breathing: Yes/No
    d. Claustrophobia (fear of closed-in places): Yes/No
    e. Trouble smelling odors: Yes/No
3. Have you ever had any of the following pulmonary or lung problems? (circle Yes or No)
    a. Asbestosis: Yes/No
    b. Asthma: Yes/No
    c. Chronic bronchitis: Yes/No
    d. Emphysema: Yes/No
    e. Pneumonia: Yes/No
    f. Tuberculosis: Yes/No
    g. Silicosis: Yes/No
    h. Pneumothroax (collapsed lung): Yes/No
    i. Lung cancer: Yes/No
    j. Broken ribs: Yes/No
    k. Any chest injuries or surgeries: Yes/No
    l. Any other lung problems that you've been told about: Yes/No
4. Do you currently have any of the following symptoms of pulmonary or lung illness? (circle Yes or No)
    a. Shortness of breath: Yes/No
    b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
    c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
    d. Have to stop for breath when walking at your own pace on level ground: Yes/No
    e. Shortness of breath when washing or dressing yourself: Yes/No
    f. Shortness of breath that interferes with you job: Yes/No
    g. Coughing that produces phlegm (thick sputum): Yes/No
    h. Coughing that wakes you early in the morning: Yes/No
    i. Coughing that occurs mostly when you are lying down: Yes/No
    j. Coughing up blood in the last month: Yes/No
    k. Wheezing: Yes/No
    l. Wheezing that interferes with your job: Yes/No
    m. Chest pain when you breath deeply: Yes/No

See Attached DD Form 2005 for PRIVACY ACT STATEMENT

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC **OHC,PMS,WRAMC**	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

NAME:

SOCIAL SECURITY NO:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

CLINICAL RECORD

Report on _____
or
Continuation of S.F. DA 4700 RESP. MEDICAL QUESTIONAIRE

(Strike out one line) (Specify type of examination or data)

(Sign and date)

n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ever *had* any of the following cardiovascular or heart problems? (circle Yes or No)
   a. Heart attack: Yes/No
   b. Stroke: Yes/No
   c. Angina: Yes/No
   d. Heart failure: Yes/No
   e. Swelling in you legs or feet (not caused by walking): Yes/No
   f. Heart arrhythmia (heart beating irregularly): Yes/No
   g. High blood pressure: Yes/No
   h. Any other heart problem that you've been told about: Yes/No

6. Have you ever *had* any of the following cardiovascular or heart symptoms? (circle Yes or No)
   a. Frequent pain or tightness in you chest: Yes/No
   b. Pain or tightness in your chest during physical activity: Yes/No
   c. Pain or tightness in your chest that interferes with you job: Yes/No
   d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
   e. Heartburn or indigestion that is not related to eating: Yes/No
   f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems: Yes/No
   b. Heart trouble: Yes/No
   c. Blood pressure: Yes/No
   d. Seizures (fits): Yes/No

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9.)
   a. Eye irritation: Yes/No
   b. Skin allergies or rashes: Yes/No
   c. Anxiety: Yes/No
   d. General weakness or fatigue: Yes/No
   e. Any other problem that interferes with your use of a respirator. Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes/No

11. Do you currently have any of the following vision problems?
    a. Wear contact lenses: Yes/No
    b. Wear glasses: Yes/No
    c. Color blind: Yes/No
    d. Any other eye or vision problem: Yes/No

12. Have you ever *had* an injury to your ears, including a broken eardrum? Yes/No

13. Do you currently have any of the following hearing problems?
    a. Difficulty hearing: Yes/No
    b. Wear a hearing aid: Yes/No
    a. Any other hearing or ear problems: Yes/No

14. Have you ever *had* a back injury: Yes/No

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet: Yes/No
    b. Back pain: Yes/No
    c. Difficulty fully moving your arms and legs: Yes/No
    d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
    e. Difficulty fully moving your head up or down: Yes/No
    f. Difficulty fully moving your head side to side: Yes/No
    g. Difficulty bending at your knees: Yes/No
    h. Difficulty squatting to the ground: Yes/No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes/No
    j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

(Continue on reverse side)

See Attached DD Form 2005 for PRIVACY ACT STATEMENT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO. OHC, PMS, WRAMC

REPORT ON _____ or CONTINUATION OF _____

Standard Form 507
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTE ON MEDICAL RECORDS
FPMR 101-11-80-6-8
OCTOBER 1975
USAPPC V1.00

WRAMC OVERPRINT 616
1 JUL 99